

within one day of discharge for 66% (n=144) of the sample. Records showed that the inpatient team communicated with family members or support persons about the patient's post-discharge treatment plan for 53% (n=114) of the sample, and 36% (n=79) attended a family meeting or therapy session. Rates of attending an aftercare behavioral health appointment were 55% (n=120) at seven days post-discharge and 80% (n=174) for 30 days.

Discussion: This study found varying rates of providers completing care transition practices. Only half of the sample had attended an aftercare appointment in the seven days post discharge, however the majority had attended an appointment by 30 days. Planned analyses will present demographic and clinical differences among those who received discharge planning activities and had family involvement. We will examine predictors of attending follow-up care and report the effectiveness of discharge planning practices. Findings will help inform strategies to improve care-coordination and discharge planning for individuals with serious mental illnesses treated in psychiatric hospitals.

O11.8. PREVALENCE AND PREDICTORS OF INTERVIEW-ASSESSED CLINICAL HIGH-RISK SYMPTOMS IN THE GENERAL POPULATION

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Background: In clinical samples, symptomatic ultra-high risk criteria and the basic symptom criterion “cognitive disturbances” perform well in predicting psychosis, and best when both approaches are combined. However, little-to-nothing is known about the prevalence, clinical relevance, and moderators of these clinical high risk (CHR) criteria and their constituent symptoms in the community.

Methods: Regression analyses involved 2683 community participants (age 16–40 years; response rate: 63.4%). Semi-structured telephone interviews were performed by well-trained psychologists.

Results: Lifetime and current CHR symptoms were reported by 21.1% and 13.8% of interviewees. Frequency of symptoms was mostly low, only 2.4% met any CHR criterion. A stepwise relationship underlay the association of the two types of CHR symptoms and criteria with the presence of mental disorders and functional deficits, with odds ratios being highest (7.4–31.8) when ultra-high risk and basic symptoms occurred together. Report of a family history of mental disorder generally increased risk for CHR symptoms. While younger age increased risk for basic symptoms, lifetime substance misuse and trauma increased risk for ultra-high risk symptoms.

Discussion: Prevalence of CHR criteria was within the range to be expected from the prevalence rates of psychoses. Clinical relevance of both CHR symptoms and criteria increased in a stepwise manner from basic symptoms via ultra-high risk symptoms to their combined presence, reinforcing the clinical utility of their combined use. The risk factors selectively associated with basic and ultra-high risk symptoms seem to support developmental models relating basic symptoms to neurobiological and ultra-high risk symptoms to psychological factors.

O12. Oral Session: Socio-Economic/Environment

O12.1. EXAMINING THE NEUROBIOLOGICAL IMPACT OF CHILDHOOD TRAUMA: AN IMPORTANT ROLE FOR FRONTAL AND INSULAR REGIONS

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Background: Childhood trauma may increase the risk for psychiatric illness by its negative impact on brain development. Studies investigating the association between childhood trauma and deviations in gray matter volume have shown inconsistent findings, often restricted by a region-of interest approach with a sole focus on the amygdala and hippocampus and without controlling for the presence of psychiatric illness.

Methods: First, using a whole-brain approach in a large cross-diagnostic sample (n=554) of healthy individuals and patients with a bipolar type-I or psychotic disorder, we investigated the neurobiological correlates of childhood trauma by evaluating gray matter volume. Follow-up analyses were conducted to evaluate the effect of psychiatric illness. Second, we investigated to what extent these trauma-related structural correlates could be observed in both groups separately (healthy individuals versus patients). Participants were recruited as part of three different studies, all conducted in the University Medical Center Utrecht (the Netherlands) between 2007 and 2016. We included 554 participants: 220 healthy individuals without a psychiatric history, 250 patients with a bipolar-I disorder and 84 patients with a psychotic disorder. Childhood trauma was evaluated with the Childhood Trauma Questionnaire (CTQ-SF). Anatomical T1 MRI scans were acquired at 3T. FreeSurfer was used to assess regional brain morphology.

Results: In the total sample, childhood trauma severity was associated with bilateral reductions in frontal and insular gray matter volumes. In the right hemisphere, medial orbitofrontal and superior frontal volume reductions were related to childhood trauma. These associations remained when adjusting for psychiatric illness, with the exception of the right superior frontal subregion. However, when evaluating both groups separately, these structural correlates of childhood trauma were mainly observed in patients. Healthy controls did show trauma related reductions in right medial orbitofrontal region, while this association was not significant in the patient group.

Discussion: Our results suggest that gray matter reductions in the frontal and insular regions are important neurobiological correlates of childhood trauma. For future research, a whole brain approach should be applied, as cortical rather than subcortical areas may be the main correlate of childhood trauma contributing to the development of psychopathology.

O12.2. STICKS AND STONES MAY BREAK MY BONES BUT WORDS INCREASE THE RISK OF PSYCHOTIC EXPERIENCES

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Background: There has been a surge of interest into the relationship between psychotic experiences (PEs) and bullying. However, the methods of bullying and impact of bullying varies across individuals and the prevalence may also vary by respondent (parent or children). For this reason, a thorough investigation into this relationship is warranted.

Methods: A longitudinal analysis was conducted on waves 1 and 2 (ages 9 and 13) of the nationally representative Growing Up in Ireland study. Data from n=7163 families were included in this study. Information regarding bullying, being a bully, bullying type, reasons for the bullying, the impact of the bullying was collected from the participating child and their primary care giver (PCG) at both waves. Psychotic experiences were reported by the child at the second wave using the Adolescent Psychotic Symptoms Screener.

Results: 13.12% of children met validated criteria for psychotic experiences. Based on the PCG's account, 32.89% of those with PEs at age 13 were bullied at age 9 and this was independently associated with PEs even after accounting for bullying at 13 (OR: 1.40, CI: 1.19–1.65). Physical, verbal, electronic bullying and bullying by exclusion were associated with an